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## **Mental health needs of clients of rehabilitation services: A survey in one Trust**

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### **Abstract**

*Background:* Little is known about the profile of current rehabilitation service users and how it might differ from the clients for whom these services were originally set up.

*Aim:* To carry out a cross-sectional survey of rehabilitation service clients within two inner London boroughs and compare mental health needs with previous data from 1998.

*Method:* All 141 clients of the four different types of rehabilitation services in Camden and Islington were included. Observer rated assessments of social function, substance misuse, mental health needs and challenging behaviours were made.

*Results:* Most clients had a diagnosis of schizophrenia or schizoaffective disorder. Around 7% had a co-morbid substance misuse problem. Over half had at least one challenging behaviour that was difficult to manage or occurred frequently. Clients in longer term hospital-based settings had the poorest social function and greatest number of needs. Compared to rehabilitation service users in 1998, clients had more unmet accommodation and money needs, but fewer unmet needs in the areas of psychological distress, psychotic symptoms and social relationships.

*Conclusions:* Few differences in client characteristics were found with the exception of those in longer term, hospital-based facilities. Improvements in symptom management and social function may have created a need for more independent accommodation.

*Declaration of interest:* None.

**Keywords:** *Survey, rehabilitation, clients*

### **Introduction**

Contemporary mental health rehabilitation services originated during the era of asylum closures, when they drove the development of community mental health services and supported accommodation for people with longer term and complex mental health problems. Although there has been a recent emphasis in the National Service Framework for Mental Health (Department of Health [DoH], 1999; 2004) on the development and implementation of specialist forms of community mental health services such as crisis resolution, assertive outreach and early intervention teams, rehabilitation services remain an important component of the whole mental health system, providing longer term inpatient

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and community-based services in most Mental Health Trusts across England (Killaspy et al., 2005). Despite their ubiquity, little is known about the profile of current users of rehabilitation services and whether these services, originally developed to re-provide for patients of the asylum and other psychiatric institutions, meet the needs of their modern day clients.

Camden and Islington Mental Health and Social Care Trust's (CIMHSCT) rehabilitation services were developed in the 1990s during the closure of Friern Hospital, which was at one time the largest asylum in Europe. Over the last six years, CIMHSCT has reorganized its rehabilitation services in order to develop a coherent "whole system" approach to rehabilitation, offering a range of facilities to support people through the different stages of their recovery (CIMHSCT, 2000; 2004). The services offer short, medium and longer term treatment and care and fall into four categories which are described in further detail in Table I.

The aim of the study was to carry out a cross-sectional survey of all clients of these services in order to provide a detailed description of a contemporary rehabilitation service user population and to investigate whether the level of support in the different types of rehabilitation setting was appropriately matched to service users' social function, mental health needs and challenging behaviours. We also sought to compare the mental health needs of current users of these rehabilitation service users with those for whom the services were set up as part of the Friern Hospital re-provision programme (McCrone, 1998).

## **Method**

### *Study setting*

The inner London boroughs of Camden and Islington have a combined population of 373,817 (National Statistics, 2001). High levels of deprivation give this area one of the highest estimated levels of psychiatric morbidity in the UK (Glover et al., 1998). Secondary mental health services are provided through the Mental Health and Social Care Trust and include psychiatric intensive care, acute admission wards, a range of inpatient and community rehabilitation services described in this paper, eleven community mental health teams, two assertive outreach teams, four crisis resolution teams and an early intervention service. There is a range of specialist and day services but no forensic service. Around 200 people are placed out of borough in nursing and residential care.

### *Study sample*

All 141 clients of the Trust's inpatient and residential rehabilitation services were eligible for inclusion in the study: 27 from short term inpatient hospital wards; 44 from medium term "wards in the community"; 50 from longer term community placements; and 20 from longer term hospital-based placements.

### *Data collection*

Data were collected between April and August 2005. Demographic details and previous service use were collected from the case records. All assessments were observer rated and

Table I. Short, medium and longer term rehabilitation facilities.

	Short term	Medium term	Longer term community	Longer term hospital
Type of facility	Two inpatient rehabilitation wards	Three "wards in the community"	Four residential care homes	Two houses in hospital grounds
Total number of service users	27	44	50	20
Expected maximum length of stay	One year	Two years	Five years	Unlimited
Staffing per facility	24 hour waking nights with full MDT: 0.3 FTE consultant rehabilitation psychiatrist; 1.0 FTE trainee psychiatrist; 1 – 2.0 FTE OT; 0.4 FTE psychologist; 3 nurses per day shift, 2 per night shift	24 hour waking nights with full MDT: 0.1 FTE consultant rehabilitation psychiatrist; 0.5 FTE trainee psychiatrist; 1.0 FTE OT; 0.2 FTE psychologist; 2 nurses or support workers per day shift, 1 per night shift	24 hour sleeping nights with limited MDT: Medical input from local CMHT; 0.2 FTE OT; 0.2 FTE psychologist; 2 support workers per day shift, 1 per night shift (sleeping)	24 hour waking nights with full MDT: 0.1 FTE consultant rehabilitation psychiatrist; 1.0 FTE trainee psychiatrist; 1.0 FTE OT; 0.2 FTE psychologist; 2 nurses per day shift, 1 per night shift

MDT, multidisciplinary team; OT, occupational therapist; FTE, full time equivalent.

service users were not interviewed. The local ethics committee approved the study. Assistant psychologists working at each site were trained in the use of the standardised assessment measures by HK and KB. They were supervised by qualified clinical psychologists at each site and co-ordinated data collection by assisting each client's keyworker or primary nurse to complete the following assessments:

- (1) Social functioning was assessed using the Life Skills Profile (LSP; Parker et al., 1991). This widely used scale, standardized on a community sample of people with a diagnosis of schizophrenia in Australia, gives ratings of five domains of social function and a total score – the higher the score, the greater the level of functioning. The maximum scores on the five domains are: self care 40; non-turbulence 48; social contact 24; communication 24; responsibility 20. The maximum possible total score is therefore 156. Two-thirds of a study population would be expected to have a total mean score somewhere in the range 104 to 136 (i.e., within one standard deviation of the mean).
- (2) Use of substances over the preceding six months was estimated using the Clinician Alcohol and Drug Use Scales (CADS; Drake et al., 1996) which gives ratings on a five point scale as follows: 1 = abstinent; 2 = use without impairment; 3 = use causing physical, psychological or social problems; 4 = dependence; 5 = dependence resulting in institutionalization. The degree of severity of substance use can also be summarized as problematic or non-problematic.
- (3) The Special Problems Rating Scale (SPRS; Trieman & Leff, 1996) was used to assess the presence and severity of 14 challenging behaviours that may make an individual difficult to place in a community setting. The severity of the problem is assessed according to the frequency and degree of difficulty in managing the behaviour and rated on a scale of 0 (no problem) to 2 (frequent and/or extremely difficult to manage). The behaviours are categorised into four types: Type A – physical violence, sexual inappropriateness or fire risk; Type B – verbal aggression, destruction of property, begging, stealing, urinating or defecating in public; Type C – substance abuse, non-compliance with medication, absconding or wandering; Type D – incontinence, risk of suicide, self harm.
- (4) The Camberwell Assessment of Need (Slade et al., 1999) was used in its abbreviated form (CANSAS) to assess 22 domains of mental health and social need identified over the previous month. These are rated as: absent (scored as 0, no problem in this domain); met (scored as 1, no or mild or moderate problem because of continuing intervention (e.g., problems with budgeting are managed through an appointeeship); or unmet (scored as 2, a current serious problem which persists despite appropriate intervention e.g. psychotic symptoms which are unresponsive to medication).

### *Data analysis*

Data were entered into the statistical software package SPSS version 11.0 and simple frequency analyses were carried out by DR. Comparisons between short, medium and longer term rehabilitation services were made using appropriate statistical tests by HK. Student's *t*-tests were used to compare normally distributed quantitative data and Mann-Whitney's *u* test was used to compare non-normally distributed data.

## Results

### *Response*

Complete data (100% response) were collected for all 141 clients for basic demographic details, source of referral and standardised assessment measures. Data on length of contact with services was unavailable for six (4%) clients and number of previous admissions was unavailable for 28 (20%) clients.

### *Source of referral to current placement*

The majority of clients were referred to their current placement from either an acute admission ward (48%) or a rehabilitation ward (40%). A small number (2%) were referred directly from a medium secure unit. Of those referred directly from the community, eight (6%) were from a residential home, two (1%) from their own home and one (<1%) from a homeless hostel. Further details are shown in Table II.

### *Demographics, length of history, diagnoses*

Around two-thirds of the clients were male. The age of the group ranged from 19–74 years with older clients in longer term units (short and medium term,  $n = 71$ , mean age 38.9 years [SD 12.6]; longer term community and inpatient,  $n = 70$ , mean age 52.0 years [SD 10.7]: difference in means 13.1,  $p < .001$ , 95% CI  $-17.0$  to  $-9.2$ ). No other statistically significant differences in demographic details were found between clients in short, medium and longer term settings. No clients were in open employment. The majority of clients had a diagnosis of schizophrenia or schizoaffective disorder with few having any secondary diagnosis recorded in the case file. The number of years that clients had been in contact with psychiatric services ranged from 1 to 54 years and was greater for those in longer term units (short and medium term,  $n = 69$ , 14.7 mean years [SD 10.1]; longer term,  $n = 66$ , 28.6 mean years [SD 10.7]: difference in means 13.9,  $p < .001$ , 95% CI  $-17.4$  to  $-10.4$ ) who also had more previous admissions to hospital (short and medium term,  $n = 63$ , 5.8 mean admissions [SD 3.8]; longer term,  $n = 50$ , 8.7 mean admissions [SD 6.5]: difference in means 2.9,  $p = .004$ , 95% CI  $-4.9$  to  $-1.0$ ). Fifteen (11%) clients (11 male and 4 female) were detained under the Mental Health Act (1983), all under Section 3, 11 of whom were in short term inpatient rehabilitation wards and four in long term inpatient settings. Further details are shown in Table II.

### *Social functioning*

The LSP scores are shown in Table III. In our sample, 27 (19%) clients had a total LSP score below 104 and 21 (15%) had a total LSP score over 136. The scores from the Australian community sample on which the assessment tool was standardized (Rosen et al., 1989) have been included in Table III for non-statistical comparison. There were no statistically significant differences in the five sub-domain or total LSP scores between clients of short, medium and long-term community settings but clients of longer term inpatient settings had significantly poorer social function on all domains except social contact and lower total mean LSP scores compared to the other groups.

Table II. Demographics, diagnosis and history.

	Total <i>N</i> = 141	Short term <i>n</i> = 27	Medium term <i>n</i> = 44	Long term (community) <i>n</i> = 50	Long term (inpatient) <i>n</i> = 20
Mean (SD) age in years	<i>N</i> = 141 45 (13)	38 (12)	40 (13)	52 (10)	53 (12)
Male (%)	<i>N</i> = 141 93 (66)	17 (63)	33 (75)	33 (66)	10 (50)
Ethnic group (%)	<i>N</i> = 141				
White	83 (59)	15 (56)	23 (52)	27 (54)	18 (90)
Black Caribbean	14 (10)	3 (11)	3 (7)	7 (14)	1 (5)
Black African	11 (8)	2 (7)	7 (16)	1 (2)	1 (5)
Black other	7 (5)	2 (7)	2 (5)	3 (6)	0 (0)
Asian	6 (4)	1 (4)	2 (5)	3 (6)	0 (0)
Other	20 (14)	4 (15)	7 (16)	9 (18)	0 (0)
Marital status (%)	<i>N</i> = 141				
Never married	107 (76)	22 (82)	36 (82)	36 (72)	13 (65)
Married/living as married	5 (4)	0 (0)	3 (7)	2 (4)	0 (0)
Divorced/separated	26 (18)	5 (18)	4 (9)	10 (20)	7 (35)
Unknown	3 (2)	0 (0)	1 (2)	2 (4)	0 (0)
Mean (SD) years contact with psychiatric services	<i>N</i> = 135 21 (12)	<i>n</i> = 27 15 (10)	<i>n</i> = 42 15 (12)	<i>n</i> = 46 28 (10)	<i>n</i> = 20 30 (13)
Mean (SD) previous admissions	<i>N</i> = 113 7 (5)	<i>n</i> = 24 6 (4)	<i>n</i> = 39 6 (4)	<i>n</i> = 38 8 (7)	<i>n</i> = 12 10 (4)
Diagnosis (%)	<i>N</i> = 141				
Schizophrenia/sczaffective	129 (91)	24 (89)	39 (89)	47 (94)	19 (95)
Bipolar affective disorder	5 (4)	2 (7)	1 (2)	1 (2)	1 (5)
Depression	3 (2)	0 (0)	2 (5)	1 (2)	0 (0)
Personality disorder	2 (1)	0 (0)	1 (2)	1 (2)	0 (0)
Asperger's syndrome	1 (1)	1 (4)	0 (0)	0 (0)	0 (0)
Other	1 (1)	0 (0)	1 (2)	0 (0)	0 (0)
Secondary diagnosis (%)	<i>N</i> = 141				
No other diagnosis	116 (83)	19 (70)	34 (77)	43 (86)	20 (100)
Substance misuse	6 (4)	4 (15)	1 (2)	1 (2)	0 (0)
Learning disability	7 (5)	1 (4)	4 (9)	2 (4)	0 (0)
Organic brain injury	1 (1)	0 (0)	1 (2)	0 (0)	0 (0)
Personality disorder	5 (4)	2 (7)	1 (2)	2 (4)	0 (0)
Schizophrenia	2 (2)	1 (4)	0 (0)	1 (2)	0 (0)
Anxiety/depression/OCD	4 (3)	0 (0)	3 (7)	1 (2)	0 (0)
Mean (SD) months in current placement	<i>N</i> = 141 49 (55)	10 (5)	18 (13)	77 (63)	96 (53)
Source of referral (%)	<i>N</i> = 141				
Medium secure unit	3 (2)	0 (0)	2 (5)	1 (1)	0 (0)
Acute ward	68 (48)	24 (89)	23 (52)	16 (32)	5 (25)
Rehabilitation ward	56 (40)	2 (7)	16 (36)	25 (50)	13 (65)
Community	14 (10)	1 (1)	3 (7)	8 (16)	2 (10)

*Substance misuse*

Table IV shows the CADS ratings for clients in each type of rehabilitation setting. Overall around 12% of all clients were rated as having a problem with substances (i.e., a score of at

Table III. Social Functioning.

	Stand-ardized comm. sample* (N = 128)	Total C&I N = 141	Short term n = 27	Medium term n = 44	Long term comm. n = 50	Long term inpt. n = 20	Difference in means** (95% CI)	p
<i>Self care</i>								
Mean (SD)	31 (6.3)	28 (6.0)	29 (5.9)	30 (5.6)	28 (7.0)	24 (5.0)	-5.28 (-8.21 to -2.35)	0.001
<i>Non turbulence</i>								
Mean (SD)	39 (6.7)	41 (6.0)	40 (5.8)	41 (6.2)	41 (5.0)	38 (5.8)	-2.66 (-5.34 to 0.03)	0.052
<i>Social contact</i>								
Mean (SD)	14 (3.9)	15 (4.0)	15 (3.5)	14 (4.0)	16 (4.4)	14 (3.2)	-0.83 (-2.75 to 1.08)	0.391
<i>Communication</i>								
Mean (SD)	19 (3.3)	19 (3.0)	20 (3.0)	20 (3.1)	20 (3.0)	18 (3.3)	-1.85 (-3.31 to -0.39)	0.013
<i>Responsibility</i>								
Mean (SD)	16 (3.3)	16 (3.0)	17 (2.9)	17 (2.5)	16 (3.3)	14 (3.0)	-2.69 (-4.10 to -1.28)	<0.000
<i>Total score</i>								
Mean (SD)	119 (17.7)	120 (16.0)	121 (14.4)	122 (15.2)	121 (15.6)	108 (16)	-13.3 (-20.6 to -6.07)	<0.001

C&I, Camden and Islington; Comm., community; Inpt., inpatient; \*From Rosen et al., 1989; \*\*long term inpatient clients compared with all other clients.



least 3). Only one participant with a substance misuse problem was in a long term inpatient setting. One participant had a problem with both alcohol and drugs.

### Challenging behaviours

Table V shows the number and proportion of each type of problem behaviour for clients in different settings. Overall, there were an average 1.4 challenging behaviours per client.

Table IV. Alcohol and illicit drug use.

	Total N = 141 (%)	Short term n = 27 (%)	Medium term n = 44 (%)	Long term (community) n = 50 (%)	Long term (inpatient) n = 20 (%)
<i>Alcohol</i>					
Abstinent	85 (60)	20 (74)	24 (55)	25 (50)	16 (80)
Non problematic use	48 (34)	5 (19)	17 (39)	23 (46)	3 (15)
Problematic use	6 (4)	1 (4)	2 (5)	2 (4)	1 (5)
Dependence	2 (1)	1 (4)	1 (2)	0 (0)	0 (0)
Dependence with institutionalization	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
<i>Illicit drugs</i>					
Abstinent	121 (86)	20 (74)	37 (84)	44 (88)	20 (100)
Non problematic use	10 (7)	4 (15)	4 (9)	2 (4)	0 (0)
Problematic use	6 (4)	2 (7)	1 (2)	3 (6)	0 (0)
Dependence	3 (2)	1 (4)	2 (5)	0 (0)	0 (0)
Dependence with institutionalization	1 (1)	0 (0)	0 (0)	1 (2)	0 (0)

Table V. Number (%) of participants in each setting exhibiting different types of problem behaviours and severity ratings for each behaviour type.

Problem behaviour type	Total N = 141 (%)	Short term n = 27 (%)	Medium term n = 44 (%)	Long term community n = 50 (%)	Long term inpatient n = 20 (%)
Type A	42 (30)	10 (37)	10 (23)	14 (28)	8 (40)
Type B	35 (25)	6 (22)	12 (27)	12 (24)	5 (25)
Type C	38 (27)	11 (41)	15 (34)	7 (14)	5 (25)
Type D	14 (9)	2 (7)	5 (11)	6 (12)	1 (5)
Mean (SD) scores of severity of each behaviour type					
Type A	0.34 (0.71)	0.56 (0.85)	0.20 (0.67)	0.32 (0.65)	0.40 (0.68)
Type B	0.45 (1.1)	0.52 (1.09)	0.41 (1.26)	0.40 (0.90)	0.55 (1.23)
Type C	0.43 (0.93)	0.74 (1.31)	0.52 (0.90)	0.22 (0.74)	0.30 (0.73)
Type D	0.13 (0.51)	0.07 (0.38)	0.14 (0.46)	0.18 (0.63)	0.10 (0.45)
Mean (SD) severity score for all behaviour types	1.57 (2.34)	2.3 (2.57)	1.48 (2.73)	1.36 (2.01)	1.35 (1.76)
Mean (SD) number of problem behaviours per client	1.40 (1.80)	1.67 (1.86)	1.45 (2.11)	1.22 (1.57)	1.35 (1.60)

Type A. Risk to others: physical violence; sexual inappropriateness; fire risk.

Type B. Antisocial: verbal aggression; destruction of property; begging; stealing; urinating/defecating in public.

Type C. Chaotic lifestyle: substance abuse; non-compliance with medication; absconding; wandering.

Type D. Impact mainly on individual: incontinence; risk of suicide; self harm.

There were no statistically significant differences in the total number or ratings of the severity of clients' problem behaviours between the different types of rehabilitation setting.

Six clients (4%) had been physically violent during the previous month, four of whom were male and two of whom were detained under the Mental Health Act (MHA). Seven (5%) clients had displayed sexually inappropriate behaviour within the previous month, four of whom were men and three of whom were detained. One male client had presented a fire risk in the previous six months. All those with Type A behaviours detained under the MHA were in short term units.

With regard to Type B behaviours, seven (5%) clients, five of whom were female, had been verbally aggressive in the previous month. Five clients had destroyed property and four had been begging. Two clients had been stealing, both of whom also had substance misuse problems. Two men had been urinating/defecating in public. Four clients with Type B behaviours were detained under the MHA.

In terms of Type C behaviours, nine (6%) clients had severe substance abuse problems in the month prior to assessment, eight of whom were men and three were detained under the MHA. One had problems with both alcohol and drugs. Six clients (four male) persistently refused medication, two of whom were detained under the MHA. Six clients (4%) had problems with wandering or absconding. Seven clients with Type C behaviours were detained under the MHA.

Of the 14 (10%) clients rated as having Type D behaviours, six were incontinent on a daily basis over the previous month, four of whom were under 60 years of age and four of whom were female. Two clients were considered a high suicide risk in the previous month (one male, one female) and two others had self-harmed in the previous three months.

#### *Assessment of health and social needs*

The number and proportion of each type of unmet need identified by the CANSAS for service users in the different rehabilitation settings are shown in Table VI. The most common unmet needs were ongoing psychotic symptoms (18%), accommodation (16%), daytime activities (16%) and money (16%). Mean total, met and unmet needs are also shown. Clients in short and medium term units had more unmet needs than those in longer term units (short and medium,  $n = 71$ , mean unmet needs = 2.14 [SD 2.85]; longer term  $n = 70$ , mean unmet needs = 1.09 [SD 2.18]; difference in means 1.06,  $p = .015$ , 95% CI 0.21 to 1.90).

Staff rated unmet needs identified by the Camberwell Assessment of Need in a previous survey of 207 clients living in specialized accommodation in Camden and Islington have been included in the Table for non-statistical comparison (McCrone, 1998). In the 1998 survey, staff and client rated needs assessments were made of individuals living in a range of specialized accommodation: registered care homes (48%), staffed homes (24%), hospital accommodation (13%), registered nursing homes (9%), adult care (3%) and unstaffed homes (3%). The registered care homes are equivalent to the long-term community settings in the current survey, the registered nursing homes are equivalent to the medium term settings ("wards in the community") and those in hospital accommodation are equivalent to the long term inpatient settings. The 1998 survey did not include patients in short term rehabilitation hospital wards and the current survey did not include those in adult care, staffed or unstaffed homes.

Table VI. Mental health needs.

Domain	C&I 1998* N = 207	Total with unmet need N = 141 (%)	Short term n = 27 (%)	Medium term n = 44 (%)	Long term comm. n = 50 (%)	Long term inpt. n = 20 (%)
Unmet needs						
Food	10 (5)	6 (4)	2 (7)	2 (5)	0 (0)	2 (10)
Psychotic symptoms	44 (21)	25 (18)	6 (22)	9 (20)	5 (10)	5 (25)
Accommodation	12 (6)	22 (16)	12 (44)	7 (16)	2 (4)	1 (5)
Psychological distress	35 (17)	16 (11)	5 (19)	5 (11)	6 (12)	0 (0)
Looking after home	10 (5)	13 (9)	3 (11)	5 (11)	5 (10)	0 (0)
Self care	13 (6)	12 (9)	3 (11)	3 (7)	5 (10)	1 (5)
Daytime activity	38 (18)	22 (16)	4 (15)	7 (16)	6 (12)	5 (25)
Money	17 (8)	22 (16)	9 (34)	6 (14)	4 (8)	3 (15)
Physical health	23 (11)	19 (13)	4 (15)	6 (14)	8 (16)	1 (5)
Information	3 (1)	2 (1)	0 (0)	1 (2)	1 (2)	0 (0)
Safety to others	8 (4)	6 (4)	3 (11)	3 (7)	0	0 (0)
Safety to self	4 (2)	4 (3)	0	2 (5)	2 (4)	0 (0)
Company	34 (16)	16 (11)	4 (15)	9 (20)	3 (6)	0 (0)
Benefits	7 (3)	4 (3)	1 (4)	2 (5)	0 (0)	1 (5)
Alcohol	7 (3)	4 (3)	2 (1)	1 (0.7)	0 (0)	1 (1)
Drugs	8 (4)	6 (4)	2 (1)	3 (2)	1 (0.7)	0 (0)
Transport	29 (14)	7 (5)	1 (0.7)	4 (2)	1 (0.7)	1 (1)
Intimate relationships	37 (18)	9 (6)	1 (0.7)	5 (3)	3 (2)	0 (0)
Sexual Expression	23 (11)	9 (6)	0 (0)	6 (4)	3 (2)	0 (0)
Education	3 (1)	4 (3)	0 (0)	4 (2)	0 (0)	0 (0)
Child care	1 (1)	1 (1)	0 (0)	0	1 (0.7)	0 (0)
Telephone	0 (0)	0 (0)	0 (0)	0	0 (0)	0 (0)
Mean total needs	8.7	8.1	7.0	8.7	6.7	11.9
Mean met needs	7.1	6.5	4.7	6.7	5.6	10.8
Mean unmet needs	1.6	1.6	2.3	2.1	1.1	1.1

## Discussion

This cross-sectional survey provides a description of a current day inner city population of users of mental health rehabilitation services. Given that the survey was carried out within a single Mental Health Trust, the results may not be generalized beyond socio-demographically similar populations. A further limitation was that we relied on observer rated instruments completed by clinical staff who knew the clients well since resources precluded the inclusion of face to face client interviews by a researcher. However, we maximized the validity of the results by the use of assessment tools standardised for similar populations and we sought to increase inter-rater reliability by training psychology assistants in the administration of the standardised instruments who then supervised data collection from clinical staff. This pragmatic approach facilitated our collection of a large amount of data from the whole rehabilitation population over a relatively short time.

The fact that a larger proportion of users of rehabilitation services were male compared to acute admission wards (57% male, CIMHSCT audit, 2005) is not a new finding and may represent gender disparity in social function that impedes community living for men with serious mental illnesses more than for women (Kendell, 1993; Sood et al., 1996). The ethnicity of the rehabilitation population did not differ from the whole population receiving care from CIMHSCT (CIMHSCT, 2005) with the exception of the longer term inpatient settings where all but one client was white. The vast majority of the rehabilitation population

had a diagnosis of schizophrenia or schizoaffective disorder but, rather surprisingly, only a small proportion had a co-morbid substance misuse problem. This is a worrying finding since it suggests that these clients are either not being referred or accepted for rehabilitation.

With the exception of the longer term inpatient settings, we found few differences between client characteristics in our short, medium and longer term rehabilitation settings in terms of social function, challenging behaviours and mental health needs. This could suggest that clients move through a system of rehabilitation resources with decreasing support not as a valid response to their recovery but simply because the system exists and has associated expected timeframes attached to each type of setting. This clearly has inherent problems in terms of client centred practice and deserves review. It is also possible that the standardized measures used were not sufficiently sensitive to detect differences between these client groups. Alternatively, it may simply reflect the chronicity and stability of problems in this client group.

We also found that some clients accessed longer term inpatient units directly from acute admission wards. A period of short term inpatient rehabilitation should be the preferred pathway to a longer term inpatient rehabilitation setting in order to facilitate appropriate assessment of a client's need for this specialist resource.

The majority of our survey population exhibited at least one type of problem behaviour. However, the types of behaviour varied across all types of setting, with no specific types of problem behaviour tending to occur more commonly in any particular setting.

Clients in longer term inpatient settings had the greatest number of needs but the proportion of unmet needs was similar to clients in all other types of rehabilitation setting. The total number of needs of this survey population did not differ greatly from those identified in the previous survey of residential service clients in Camden and Islington (McCrone, 1998). However, there were some differences in the types of unmet need identified: the 2005 survey found a greater proportion of clients with unmet accommodation and money needs, but a smaller proportion with unmet needs around psychological distress, use of public transport, company and intimate relationships compared to the 1998 survey. These results could reflect a shift in the ethos within contemporary rehabilitation services towards "move on" such that future accommodation and financial needs were being identified in the current placement. They could also reflect a more obvious struggle to live in the community on a small income in 2005 than 1998, and better awareness of service users' preferences for more independent accommodation (Tanzman, 1993; Owen et al., 1996). Finally, it may be that the well resourced rehabilitation services in this survey were offering more support with symptom management and socially inclusive activities than those surveyed in 1998.

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